Addressing Implicit Bias in Nursing: A Review

Unconscious preconceptions can undermine therapeutic relationships and reinforce health disparities.

ABSTRACT: This article examines the nature of implicit, or unconscious, bias and how such bias develops. It describes the ways that implicit bias among health care providers can contribute to health care disparities and discusses strategies nurses can use to recognize and mitigate any biases they may have so that all patients receive respectful and equitable care—regardless of their race, ethnicity, religion, sexual orientation, gender identification, socioeconomic status, disabilities, stigmatized diagnoses, or any characteristic that distinguishes them from societal norms.

Keywords: culturally competent care, discrimination, health care disparities, health care providers, implicit bias, minorities, patient-centered care, prejudice, vulnerable populations

In the late 1800s, Sigmund Freud popularized the idea that the unconscious mind—that is, the attitudes and feelings of which we are unaware—can have a powerful influence on our behavior. Today, unconscious attitudes that precipitate unintentional discriminatory behavior are called "implicit bias." Not surprisingly, implicit biases exist among people of all professions. But when nurses and other health care providers harbor implicit biases, they may contribute to the health care disparities experienced by members of racial, ethnic, or religious minorities and other groups that face discrimination because of such factors as sexual orientation, gender identification, disability, or stigmatized diagnoses. Fortunately, there are strategies we can use to recognize unconscious negative attitudes we may have toward various groups of patients. And with awareness comes the possibility of overcoming our implicit biases, so we can consistently adhere to the first principle in the *Code of Ethics for Nurses with Interpretive Statements*: "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person."[1]

This article briefly describes the types of health care disparities that persist in the United States, the numerous patient populations that encounter them, and the ways implicit bias contributes to these disparities by adversely affecting patient assessment, treatment decisions, and health care follow-up. It also discusses strategies nurses and other clinicians can use to discover and overcome their own implicit biases.

DISPARITIES IN HEALTH CARE

In 2003, the Institute of Medicine (IOM) produced a report based on a comprehensive literature review of racial and ethnic health care disparities that exist in the United States.[2] The report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*

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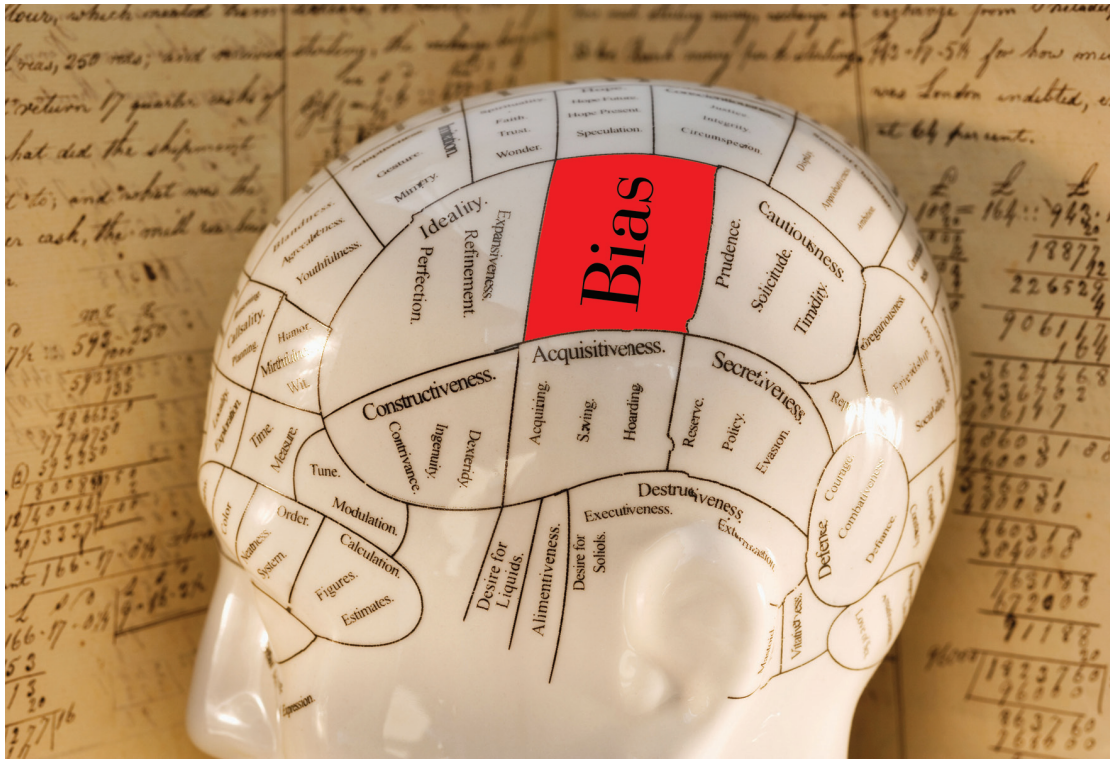

Care, noted that "racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled." The IOM cited numerous studies providing substantial evidence that patients belonging to racial and ethnic minority groups confront lack of access as well as inappropriate, inadequate, and uncaring health services.

The terms "health care disparities" and "health care inequities" refer to the poorer health outcomes observed in minority and other vulnerable patient groups compared with those observed in majority or dominant patient populations. Disparate patient outcomes are associated with age, sex, religion, socioeconomic status, sexual orientation, gender identification, disability, and stigmatized diagnoses (for example, HIV, obesity, mental illness, and substance abuse).[3] These disparities challenge our nation's commitment to equality.

Inequitable health care remains prevalent in the United States.[4-7] Each year since 2003, the Agency for Healthcare Research and Quality has produced the *National Healthcare Quality and Disparities Report*. Using many different indicators of health care access, process, and outcomes, these reports have repeatedly shown that in the aggregate white patients receive better quality of care than patients who are black, Hispanic, Asian, Native American, Alaska Native, Native Hawaiian, or Pacific Islander.[8] The U.S. Department of Health and Human Services challenged health care providers to eliminate these disparities in its publications *Healthy People 2010* and *Healthy People 2020*, and with the newly proposed Healthy People 2030 goals, which are now online (see www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework).[9,10] All three include among their overarching goals increased longevity and quality of life, as well as the elimination of U.S. health care disparities. *Healthy People 2020* adds to these goals the creation of "social and physical environments that promote good health for all" and the promotion of "healthy development and healthy behaviors across all life stages." The Joint Commission and the Institute for Healthcare Improvement (IHI) echo these goals, urging health care providers to evaluate and address disparities in their personal practices.[11,12]

IMPLICIT BIAS AND HEALTH CARE DISPARITIES

There are many reasons for health care disparities in the United States, but the IOM reported that one of the contributing factors is clinician bias toward patients of racial, ethnic, or cultural minorities.

Implicit biases among health care providers are associated with the following negative effects on patient care[4-7]:

- inadequate patient assessments
- inappropriate diagnoses and treatment decisions
- less time involved in patient care
- patient discharges with insufficient follow-up

THE NATURE OF IMPLICIT BIAS

Implicit bias is part of the human condition. To be human is to prefer familiar people. Even very young babies learn to differentiate "my family" from "others," and to see their families as "safe" and "others" as potentially dangerous. As we grow and develop, we are exposed to massive amounts of data about people and phenomena. To manage this information, we unconsciously categorize and assign judgments (with good or bad connotations) to the data. For example, we may determine that one particular group is trustworthy or pleasant and another is dangerous or disagreeable. Then, as we encounter new representatives of these groups, we respond automatically, based on our prior value judgments.

Implicit bias is theorized to be rooted in heuristics—that is, mental shortcuts that help us sum up and respond to situations quickly.[13] Based on approaches that worked for us in the past, we develop strategies that help us interact automatically in new situations with representatives of previously encountered groups of people. Our default reactions can help us manage our day-to-day activities by allowing us to assess and act quickly, without deliberation. For example, if you're in the middle of a street and a car is headed your way, you don't try to determine how fast the car is going, who is driving the car, or whether they will stop to avoid hitting you; rather, you hurry across the street. Heuristics often make life easier or safer and our choices more efficient. They play an important role in helping us navigate our environment. But our automatic responses can generate subtle discriminatory behaviors, which in a clinical context can result in poor health care delivery.

Stereotypes are often pejorative characterizations of groups of people that are frequently based on limited previous encounters or poor sources of information, including the people who raised us, our culture, media reports, or anecdotes, and they are often unconsciously internalized.

Despite an individual's commitment to egalitarian values, implicit biases may be triggered by hidden perceptions, attitudes, or memories.[5,14] The tendency to default to our implicit biases is heightened in stressful situations,[6] perhaps because in such situations we have less time and energy to consider whether our initial impressions are correct or whether our behavior aligns with our personal values and commitment to treat others equitably and with respect.

IMPLICIT BIAS IN HEALTH CARE PROVIDERS

Few studies have specifically investigated implicit bias among nurses or included large numbers of nurses among study participants. Those that have address only a few vulnerable patient populations and indicate that nurses may be subject to implicit biases when caring for patients who are elderly[15]; obese[16]; lesbian, gay, bisexual, or transgender (LGBT)[17]; mentally ill[18]; or who use injection drugs.[19] Studies of implicit bias in nurses based on race, ethnicity, religion, disability, or stigmatized diagnoses are difficult to find, though small numbers of nurses were included in some studies of implicit bias among health care providers that address these predispositions.

Nurses with implicit biases may demonstrate less compassion for certain patients and invest less time and effort in the therapeutic relationship with them, adversely affecting assessment and care.

Much of the research focused on implicit bias in physicians or health care teams indicates that providers' biases influence their relationships with patients, the care they provide, and the patients' health outcomes. Two comprehensive systematic reviews and two narrative reviews of studies on the topic shed light on the nature of implicit bias among health care providers, its manifestations and effects on patients, and the situations that promote or exacerbate it.

In their systematic review, FitzGerald and Hurst analyzed 42 studies about health care provider biases, including those related to race, ethnicity, socioeconomic status, literacy, and other factors that render patients vulnerable to stigmatization.[5] Of the 42 studies they reviewed, 15 measured biases using an Implicit Association Test (IAT), two used subliminal priming, and 25

used the "assumption method," which measures participant differences in response to clinical vignettes that are identical except in one respect, such as the race of the subject. The authors suggested that implicit bias among health care providers occurred at about the same rate as it did in the population at large. In 20 of the 25 studies that used the assumption method, they found that provider biases appeared to have influenced diagnoses, treatment recommendations, thoroughness of patient histories, or the number of tests that were ordered. They also noted a negative correlation between the level of implicit bias and indicators of quality care, a finding they suggest points to an increased likelihood of poorer outcomes.

Similarly, a systematic review conducted by Hall and colleagues found that most health care providers harbor implicit bias toward people of color. This bias is reflected both in providers' interactions with patients and in providers' treatment decisions, thereby affecting patient adherence and outcomes, with patients' psychosocial health outcomes (for example, social integration, depression, and life satisfaction) more adversely affected by provider bias than physical health outcomes.[6]

A narrative review by Chapman and colleagues found that providers with high levels of implicit bias were perceived by black patients as having poorer communication skills, delivering a lower quality of care, and being "less warm, friendly, and team oriented." The investigators contend that these perceptions could reduce patient adherence, return for follow-up appointments, and trust in health care providers.[4]

Zestcott and colleagues cite studies in their narrative review indicating that providers with implicit biases spend less time listening to black patients and that, in the absence of any supportive evidence, providers hold implicit assumptions that black and Hispanic patients are less likely to adhere to treatment and are less cooperative than white patients.[7] They note one study suggesting that providers' difficulty communicating with Hispanic patients may explain some of the implicit bias directed at that group and suggest additional research exploring whether implicit biases are less likely to influence care in the presence of clear clinical guidelines that outline evidence-based best practices.

As with physicians and other health care providers, nurses with implicit biases may demonstrate less compassion for certain patients and invest less time and effort in the therapeutic relationship with them, adversely affecting assessment and care.

STRATEGIES FOR MANAGING IMPLICIT BIAS

Social scientists have developed strategies that have been shown to mitigate implicit biases. These include counterstereotypic imaging, emotional regulation, habit replacement, increasing opportunities for contact, individuation, mindfulness, partnership building, perspective taking, and stereotype replacement.[11, 12, 20-28] (See Table 1.[11, 12, 20-28]) Health care providers can view these strategies as tools, putting those they find most effective into their own personal bias-fighting toolkit.

Recommendations from the Joint Commission and IHI. The Joint Commission specifically recommends that health care providers use emotional regulation (controlling thoughts and emotions during clinical encounters), partnership building (working with patients as equals toward the common goal of helping them achieve good health), and perspective taking (trying to understand the perspective of the patient) to decrease biases that may lead to health care disparities.[12] In addition to partnership building and perspective taking, the IHI recommends reducing bias with counterstereotypic imaging (imagining the stereotyped person as the opposite of the stereotype), individuation (learning about the personal history of the individual), increasing opportunities for contact with people from different groups (developing relationships with members of a different group with the goal of dissolving stereotypes), and stereotype replacement (consciously replacing negative images of a group with positive images).[11]

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Strategies based in nursing practice. *Habit replacement* will seem familiar to many nurses because it's very similar to the teaching and coaching techniques we use when encouraging patients to change harmful lifestyle behaviors like smoking or eating a high-fat or high-sodium diet. And just as a single patient teaching session is unlikely to help a patient change lifestyle behaviors, Lai and colleagues found that one-time interventions to mitigate health care provider biases, though initially effective, did not change behavior over time.[27] Instead, nurses can use habit-breaking strategies in conjunction with bias-mitigating strategies by employing their own personal toolkit of bias-breaking interventions.[23] They can design an action plan to dissolve implicit biases with new behaviors. The plan could include the following steps:

- Recognize the habit's damaging effects (for example, inequitable health care and disparate patient outcomes).

- Make a commitment to break the habit, recalling the *Code of Ethics for Nurses*[1] and the values that brought you to nursing.
- Use several of the bias-mitigating strategies listed in Table 1.
- Persistently practice the more desirable habits using the bias-mitigating strategies you find most effective.

The habit of nonbiased thinking needs to be consciously practiced over time. Each strategy in the toolkit can help reinforce the others,[23] and eventually the habit of biased thinking can to a greater or lesser degree be replaced by the habit of nonbiased thinking.

Mindfulness is another bias-management strategy familiar to nurses. The specific goal of mindfulness is to empty the mind of distracting thoughts so

Table 1. Self-Interventions to Mitigate Implicit Bias[11, 12, 20-28]

Strategies	Description	Recommended by
Counterstereotypic imaging	Nurse, recognizing bias, purposely identifies members of a group who counter the stereotypical image of the group, and replaces the automatic biased image with the positive image. Related to mindfulness.	Institute for Healthcare Improvement, 2017
Emotional regulation	Nurse reflects on "gut feelings" and negative reactions (dislike, fear, frustration) to patients from vulnerable groups. Nurse then intentionally strives to be empathetic, patient, and compassionate. Related to mindfulness and perspective taking.	Joint Commission, 2016
Habit replacement	Nurse frames recognized biases as bad habits to be broken. Develops and uses a personal toolkit of self-interventions to replace the bad habit of biased thinking with the good habit of accepting and caring about each patient as an individual. Related to emotional regulation, individuation, mindfulness, and strategies nurses use to help patients change harmful lifestyle behaviors.	Devine and colleagues, 2012
Increasing opportunities for contact	Nurse seeks to develop relationships with members of a group to which the nurse does not belong, with the goal of dissolving stereotypes.	Institute for Healthcare Improvement, 2017
Individuation	Nurse mindfully seeks to see patients as individuals instead of as members of a stigmatized group. Related to therapeutic relationship, patient-centered care, and culturally competent care.	Institute for Healthcare Improvement, 2017
Mindfulness	Nurse purposely takes the time to calm thoughts and feelings by being mindful of the present moment, which can help the nurse act compassionately toward the patient. Related to emotional regulation and perspective taking.	Burgess and colleagues, 2017
Partnership building	Nurse intentionally frames the clinical encounter as one in which the nurse and patient are equals, working collaboratively toward the same goal.	Institute for Healthcare Improvement, 2017, and Joint Commission, 2016
Perspective taking	Nurse purposely and empathetically thinks about what the patient is thinking and feeling, stimulating feelings of caring and compassion. Related to mindfulness and therapeutic relationship.	Institute for Healthcare Improvement, 2017, and Joint Commission, 2016
Stereotype replacement	Nurse reflects on negative reactions to members of vulnerable populations, acknowledges stereotypical responses, considers reason for the feeling, and commits to respond with compassion in the future. Related to self-reflection.	Institute for Healthcare Improvement, 2017

that we might focus on the present moment, without assumptions or judgments.[29] It allows us to be more deliberative in our actions and enables us to recognize our biases before we automatically act on them. Mindfulness interventions have been used to reduce stress and to improve provider–patient communication.[28] The concept of mindfulness is related to the ethical concepts of empathy and compassion, which are cornerstones of nursing.

Ponte and Koppel suggest using the S.T.O.P. mindfulness technique developed by Elisha Goldstein to become mindful of the assumptions we want to avoid or the values we want to bring to our patients.[28,30] Before entering the patient's room, a nurse might take several seconds to do the following:

- Stop what you're doing.
- Take some slow, deep breaths.
- Observe your thoughts, feelings, and assumptions.
- Proceed with patient care.

The goal of this practice is to help nurses recognize what they are feeling about the patient, so they can ground themselves in the values they wish to bring to the patient encounter.

anxious, or fearful. Such feelings may indicate implicit bias and prompt self-reflection. Thoughtfully reflecting on the meaning and origin of such feelings and whether they influence the quality of relationships with patients can help nurses acknowledge and control previously unrecognized biases.

IATs. Another way to discover implicit biases is to take one or more of the IATs available at Project Implicit (https://implicit.harvard.edu/implicit/education.html), an international, nonprofit organization founded in 1998 by scientists from the University of Washington, Harvard University, and the University of Virginia.[31] This website contains 14 instruments for measuring some of the most prevalent biases—those related to race, ethnicity, skin color, religion, age, gender, overweight or obesity, sexual orientation, or disability. The web-based instruments developed by the Project Implicit research group are the tools most widely used by researchers investigating biases.[5,31] According to the program manager of Project Implicit, in 2018, approximately 25 million people had completed, or at least started taking, the tests on this website (e-mail communication, April 2019). The tests are readily accessible, without cost,

One way to discover implicit biases is to pay attention to gut feelings. Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any group makes them feel uncomfortable, anxious, or fearful.

Burgess and colleagues have proposed that health care providers can use mindfulness techniques to recognize, reduce, and control implicit biases.[22] They cite literature suggesting that mindfulness can reduce implicit biases among health care providers by preventing the triggering of automatic stereotypic reactions and can enable clinicians to recognize and moderate their biases even after they have been triggered. They cite studies suggesting that mindfulness promotes compassion. Since stressed clinicians are more likely to rely on their automatic (potentially biased) first impressions, reducing stress lessens the risk of implicit bias in clinical encounters.

RECOGNIZING IMPLICIT BIASES

One way to discover implicit biases is to pay attention to gut feelings. Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any particular group of patients makes them feel uncomfortable,

to anyone who seeks to understand more about their hidden biases. Each test takes about 10 minutes to complete. The tests consist of images and evaluative statements that the test taker is instructed to sort as quickly as possible.

After completing a test, test takers immediately receive their results. Although it can be upsetting to receive results indicating potential implicit biases, learning about these can enable people to employ strategies to reduce them or mitigate their effects on future interactions. Although the IATs are reliable and valid research instruments, their developers explicitly state that, at their current stage of development, they should not be used to diagnose bias but rather as educational tools.[31]

It's important to remember that implicit bias is different from prejudice. Implicit bias means we have the instinctive tendency to evaluate other groups against the norms of our own groups. Prejudice, on the other hand, means that one feels consciously and

overtly that some groups are inferior, an attitude that can be used to justify discriminatory actions.

ADHERING TO NURSING'S BEST PRACTICES

Nursing's best practices include the development of strong therapeutic relationships and the provision of culturally competent, patient-centered care.[32, 33] Nurses who are committed to these practices form positive relationships with their patients, which dissolve bias.

Therapeutic relationships. To be successful in meeting patients' health goals, nurses are encouraged to establish a therapeutic relationship with each of their patients. The key to a therapeutic relationship is true caring for the patient.[34] Caring therapeutic relationships start with getting to know patients and their unique values, priorities, challenges, and strengths. Understanding each patient's perspective, the nurse works with the patient to achieve the patient's health care goals.

Patient-centered care emphasizes patients as collaborative partners with unique psychosocial needs that are as important as their clinical needs.[35] Patient-centered care requires us to listen carefully and respectfully to patients until we understand them as individuals with unique needs and preferences, though they may belong to groups with which we are unfamiliar or uncomfortable. With understanding, we can develop care plans that meet patients' psychosocial needs, including those for respect and consideration.

Culturally competent care. Patients whose background differs from that of their care providers in any way (race, ethnicity, religion, sexual orientation, gender identification, socioeconomic status, disabilities, stigmatized diagnoses, or any characteristic that distinguishes them from societal norms) are entitled to receive care that is effective and respectful of their cultural differences. Culturally competent care is an intrinsic element of the patient-centered care initiative.[36] Culturally competent care is patient-centered care, and patient-centered care is culturally competent care.

Embedded in each of these concepts are the strategies of individuation, perspective taking, and partnership building. Together, these approaches subvert the negative automatic responses that characterize implicit bias, enabling us to meet our patients' need for individualized respectful care.

Individuation requires us to listen carefully and respectfully to patients, seeking to understand their perspectives, experiences, values, preferences, and hopes.

Perspective taking challenges us to understand what patients are thinking and feeling, to see their illness through their eyes. This can often be accomplished when we show genuine interest in patients and ask them about their experience with their current illness and the way it affects their families and lives.

Partnership building recognizes the important role patients have in their own care. Nurse and patient collaborate, aligning the care plan with the patient's goals in order to promote patient adherence and well-being.

WHEN BIASES PERSIST

Implicit biases are difficult to eliminate, but when nurses acknowledge those they have, they can try to understand their origin and work to ensure that they do not adversely affect patient care. Health care agencies and facilities can guide clinicians toward unbiased care by supporting clear practice guidelines, such as those published by professional organizations for disease management and organizations promoting equitable care. Such guidelines provide a clear path to good care, limiting the influence of implicit biases by leaving little open to subjective interpretation in terms of assessment, diagnosis, treatment, and follow-up.[37] In addition, health care organizations can

- provide educational sessions on the causes and effects of implicit bias, as well as mitigation strategies.
- seek to reduce factors, such as inadequate staffing, that create stress, putting staff at risk for inappropriately using heuristics to guide care.

When individual nurses work to recognize biases and employ strategies to counter them, and health care organizations seek to reduce stress that can perpetuate the inappropriate use of heuristic responses, we grow in our abilities to develop therapeutic relationships and to provide culturally competent and patient-centered care. In the process, we advance the proposed Healthy People 2030 goal of eliminating health care disparities in the United States. ▼

For 22 additional continuing nursing education activities on the topic of patient-centered care, go to www.nursingcenter.com/ce.

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